

3197

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Charles</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Md.</b>		b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>none</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Rosanna Battles</b>		First	Middle	Last	4. DATE OF DEATH <b>March 2 1960</b>	Month	Day	Year 19	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>C.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5 1867</b>	9. AGE (In years lost birthday) <b>92</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>George Alfred Battles</b>		14. MOTHER'S MAIDEN NAME <b>Adeline Hawkins</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Jessie Jenkins, Indian Head, Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		<b>Senility - old age</b>		<b>years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
		<b>Chronic Myocardial weakness</b>		<b>years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Dec 31, 1959</b>		(County)	(State)
21. I certify that I attended the deceased from alive on <b>Dec 31, 1959</b> to <b>Mar 2, 1960</b> , that I last saw the deceased and that death occurred at <b>1012 1/2 St. M.</b> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED <b>3/5/60</b>	
ACTUAL SIGNATURE <b>Vahéh M. Seron</b>		M.D.		<b>Aquasco Md</b>					
PHYSICIAN'S NAME (Type) <b>VAHÉH M. SERON MD</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-7-60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Pauls Cemetery</b>		22d. LOCATION (City, town, or county) <b>Waldorf, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home, Waldorf, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Arthur L. Kraus</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			
				DATE <b>MAR 8 '60</b>					

## CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - STATE OF MARYLAND

Date:

Report No. 00000000

Place:

Date of Birth:

Age:

Cause of Death:

Sex:

Race:

Marital Status:

Occupation:

Employment:

Religion:

Education:

Health:

Employer:

Address:

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03174

3198

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN 1b 6 days.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural.	
3. NAME OF DECEASED (Type or print) William Ruth		First Penn	Middle Bowling
4. DATE OF DEATH March 8 1960		Lost	Month Day Year
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 100 Oct 1890
9. AGE (In years lost birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Westby Penn		14. MOTHER'S MAIDEN NAME Senny PENN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-36-3362	
17. INFORMANT LaRue P. Bowley		Address Fairlawn	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X DUE TO Respiratory collapse Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Hemorrhage of esophageal varix (c) DUE TO Cardio-vascular - hypertension disease		INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>8 Mar</u> , 19 <u>60</u> that I last saw the deceased alive on <u>8 March</u> , 19 <u>60</u> , and that death occurred at <u>11:55 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Arthur O. Wooldy</u> PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOOLDO</u>		ADDRESS (Street, city or town, state) <u>JARWOOD CLINIC</u> DATE SIGNED <u>8 Mar 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/11/1960	
22c. NAME OF CEMETERY OR CREMATORIUM Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Dentsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. H. Funeral Home, Inc.		24a. REC'D BY REGISTRAR DATE MAR 14 '60	
ADDRESS C. H. Funeral Home, Inc. La Plata, Md.		24b. REGISTRAR'S SIGNATURE C. H. Funeral Home, Inc.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



03175

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3199 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, and may be pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville (Rural)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville (Rural)		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First ALTON	Middle AUSTIN	Last Briscoe	4. DATE OF DEATH MARCH 20 1960	Month MARCH	Day 20	Year 1960
5. SEX M		6. COLOR OR RACE Colored	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH NOV. 2, 1929	9. AGE (in years last birthday) 30 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Bus Driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CHARLES CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME AUSTIN BRISCOE				14. MOTHER'S MAIDEN NAME LUCY SMITH				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No. (Yes)		16. SOCIAL SECURITY NO.		17. INFORMANT MR. AUSTIN BRISCOE - Hughesville MD		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 981X Conditions, if any, which gave rise to immediate cause (a), slating the underlying cause last.		DUE TO (b) GUNSHOT + WOUND of PROFOUND		INTERNAL HEMORRHAGE		INTERVAL BETWEEN ONSET AND DEATH 3-20-60		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE E. J. Edelen						DATE SIGNED 3-20-60		
EXAMINER'S NAME (Type) E. J. Edelen M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-25-60	22c. NAME OF CEMETERY OR CREMATORIAL St. Marys	22d. LOCATION (City, town, or county) Bryantown, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		ADDRESS The Hunt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR DATE MAR 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03176

## CERTIFICATE OF DEATH

Reg. Dist. No.

3200

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryantown		c. LENGTH OF STAY IN 1b /	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bryantown	
3. NAME OF DECEASED (Type or print) HARRY RAY COBURN		4. DATE OF DEATH March 19 1960	Month Day Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> April 10, 1882	9. AGE (In years last birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10b. KIND OF BUSINESS OR INDUSTRY Medical Profession	
11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Coburn		14. MOTHER'S MAIDEN NAME Harriett Coburn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes.		16. SOCIAL SECURITY NO. W.W. 1 030-24-2734	
17. INFORMANT Mrs. Gertrude Coburn (Wife) Bryantown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 20 minutes 2 years 7 years	
Coronary Thrombosis, Acute Coronary Sclerosis Generalized Arterio-Sclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Very</u> , 1956 to <u>MARCH 19</u> , 1960, that I last saw the deceased alive on <u>MARCH 2</u> , 1960, and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John H. Griffin, M.D.		3/20/60	
PHYSICIAN'S NAME (Type) John H. Griffin, M.D.		Hughesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3/21/1960	
22c. NAME OF CEMETERY OR CREMATORIAL Lee Funeral Home, Inc.		22d. LOCATION (City, town, or county) Washington, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Arehart Funeral Home, Inc.		24a. REC'D BY REGISTRAR DATE MAR 30 '60	
ADDRESS Arehart Funeral Home, Inc. - La Plata, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of the death.



03177

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing "Record 'pending'" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

3201		Reg. Dist. No.	
<b>1. PLACE OF DEATH</b> a. COUNTY <i>Charles</i> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i> <b>b. COUNTY</b> <i>Charles</i>	
<b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		<b>c. LENGTH OF STAY IN 1b</b> <i>Life</i>	
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address)		<b>e. STREET ADDRESS</b> <i>La Plata</i>	
<b>3. NAME OF DECEASED</b> (Type or print) <i>John Spencer Dorsey</i>		<b>First</b> <i>John</i>	<b>Middle</b> <i>Spencer</i>
<b>4. DATE OF DEATH</b> <i>2 22 1960</i>		<b>Month</b> <i>2</i>	<b>Day</b> <i>22</i>
<b>5. SEX</b> <i>Male</i>		<b>6. COLOR OR RACE</b> <i>Negro</i>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
<b>8. DATE OF BIRTH</b> <i>5-29-00</i>		<b>9. AGE (in years last birthday)</b> <i>54 yrs.</i>	<b>IF UNDER 1YEAR</b> Months <input type="checkbox"/> Days <input type="checkbox"/>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Labover</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>State Road</i>	
<b>11. BIRTHPLACE</b> (State or foreign country) <i>Maryland</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>	
<b>13. FATHER'S NAME</b> <i>John F. Dorsey</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Mary Ophelia Bowman</i>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <i>NO</i>		<b>16. SOCIAL SECURITY NO.</b> <i>213-16-4547</i>	
<b>17. INFORMANT</b> <i>Evangeline Dorsey, La Plata, Md.</i>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Coronary Occlusion</i> DUE TO (c) <i>Coronary Heart Disease</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>3-22-60</i>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour o. m. <i>19</i> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		<b>DATE SIGNED</b> <i>3-22-60</i>	
<b>ACTUAL SIGNATURE</b> <i>E. J. Edelen</i>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i>		<b>22b. DATE THEREOF</b> <i>3-25-60</i>	
<b>22c. NAME OF CEMETERY OR CREMATORIAL</b> <i>Newtown M.E.</i>		<b>22d. LOCATION (City, town, or county)</b> <i>La Plata</i>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Huntt Funeral Home, Waldorf Md.</i>		<b>24a. REC'D BY REGISTRAR</b> DATE <i>MAR 28 '60</i>	
		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Clinton S. Kraus</i>	

WEDNESDAY, SEPTEMBER 23, 1942

WEDNESDAY, SEPTEMBER 23, 1942

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03178

3292

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Life		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Chesapeake		Maryland						Maryland		Charles		Pisgah	

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Irving Alexander			FRANKLIN	24	3	24	1960

5. SEX	6. COLOR OR RACE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
M	W			June 7, 1891	68 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	U.S. Govt.	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph S. Franklin	Mary Milstead.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	No	Mervin A. Franklin, 54 Sergeant Ave.	Somerville, Mass.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		3-24-60	
977X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Hemorrhage	
(b) DUE TO Knife wound of throat		3-24-60	
(c) DUE TO Self inflicted		3-14-60	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
Self inflicted knife wound of throat						
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 3 24 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Chesapeake	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
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ACTUAL SIGNATURE E. J. EDELEN	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 3-24-60
EXAMINER'S NAME (Type) E. J. EDELEN M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-29-60	22c. NAME OF CEMETERY OR CREMATORIAL Chesapeake Methodist	22d. LOCATION (City, town, or county) Chesapeake, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home, Waldorf, Md.	ADDRESS	24a. REC'D BY REGISTRAR MAR 30 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Traut	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

جامعة تونس ١٩٨١

12.25      ~~bioSEM~~      1.0 2.5      ~~bioSEM~~  
bioSEM      SEM      ~~bioSEM~~ 2.19.23  
12.25 ~~bioSEM~~      SEM      ~~bioSEM~~ 2.19.23

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03179

## CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Charlottesville</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Charlottesville</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charlottesville</b>		c. LENGTH OF STAY IN 1b <b>104 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charlottesville</b>	
d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Annie (NM N.) Griffith</b>		4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>3-4-74</b>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) <b>85 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>The Plains, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Griffith</b>		14. MOTHER'S MAIDEN NAME <b>Mary</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Mary D. Ottishead, Darbury, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Breast</b> DUE TO <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), slothing the under- lying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>34 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 1959</b> to <b>March 1, 1960</b> , that I last saw the deceased alive on <b>Feb 27, 1960</b> , and that death occurred at <b>12:30 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Frank A. Susan M.D.</b>		ADDRESS (Street, city or town, state) <b>5 Indian Head Ave</b> DATE SIGNED <b>3-1-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-3-60</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Charlottesville Baptist Church</b>		22d. LOCATION (City, town, or county) <b>Charlottesville</b> (State) <b>VA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archart Funeral Home, Inc. - La Plata, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 14 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>John S. Mason</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

03180

1. PLACE OF DEATH a. COUNTY		Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Physicians Memorial		X Newport		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
MALE Negro		ALVIN	Maynard	HICKS	MARCH	29	1960	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
MALE Negro		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	Mar 13 1959	1 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Infant				Maryland				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Geraldine Hicks			Address	
James Scott		16. SOCIAL SECURITY NO.		None Geraldine Hicks Newport, Md.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		INFORMANT						
NO								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			INTERVAL BETWEEN ONSET AND DEATH			
		526 x DUE TO Acute infectious bronchitis			24 hrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO						
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Spasmodic Laugitis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)			Spontaneous illness			
no accident		While at work <input type="checkbox"/> at work <input type="checkbox"/>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
no injury 19						La Plata, Charles, Md.		
21. I certify that I attended the deceased from 3-25-60, 19		to 3-29-60 19		, that I last saw the deceased		alive on 3-28-60, 19		
alive on 3-28-60, 19		, and that death occurred at 2 P		M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE		V. B. DETTOR		M.D.		DATE SIGNED		
PHYSICIAN'S NAME (Type)		V. B. DETTOR, M.D.		La Plata, Md.		3/29/60		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORI		22d. LOCATION (City, town, or county) (State)		
Burial		3-31-60		Trinity		Newport, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
The Hunt Funeral Home, Waldorf, Md.				APR 4 '60		Arthur S. Krause		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3205

## **CERTIFICATE OF DEATH**

Reg. Dist. No.

03181

1. PLACE OF DEATH o. COUNTY		Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Md		b. COUNTY		Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans Road		c. LENGTH OF STAY IN 1b 20 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bryans Road		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION											
3. NAME OF DECEASED (Type or print)		First Rachel	Middle Warren	Last Hurlburt	4. DATE OF DEATH	Month March		Day 16	Year 1960		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-9-89	9. AGE (In years lost birthday) 70 yrs.	IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Allegheny, Penna		12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME John S. Warren		14. MOTHER'S MAIDEN NAME Eunice H. Compton									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Dr. Lloyd Hurlburt S., Bryans Road, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) (c)		DUE TO Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 2 wk					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Indian Head, Md.		(County)		(State)	
21. I certify that I attended the deceased from <u>Oct. 6</u> , 1959, to <u>3/16</u> , 1964, that I last saw the deceased alive on <u>3/15</u> , 1964, and that death occurred at <u>M.</u> from the causes and on the date stated above.											
ACTUAL SIGNATURE Frank G. Susan		M.D.		ADDRESS (Street, city or town, state) 5 Indian Head Ave		DATE SIGNED 3-16-64					
PHYSICIAN'S NAME (Type) Frank A Susan M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-18-60		22c. NAME OF CEMETERY OR CREMATORIUM Bumpy Oak		22d. LOCATION (City, town, or county) Pomonkey, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE The HUNTT Funeral Home, Waldorf, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan					

- HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital attending physician.
- FUNERAL DIRECTOR:** After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3230

03182

## CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
Charles MARYLAND		Md., Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville-Rural Life		c. LENGTH OF STAY IN 1b 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville - Rural	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Month Day Year	
First MARY Middle K. JAMESON		March 26, 1960	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1885	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Klinkiewicz		14. MOTHER'S MAIDEN NAME Fannie Wheatley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-34-8235 17. INFORMANT Walter A. Jameson Sr., Hughesville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to Mar 26, 1960, that (I) (we) last saw the deceased alive on Mar 26, 1960, and that death occurred at 8 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 3-26-60	
22a. SIGNATURE Roy Guyther		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Roy Guyther		22d. ADDRESS Mechanicsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-28-60	
23c. NAME OF CEMETERY OR CREMATORIAL St Marys		23d. LOCATION (City, town, or county) Bryantown, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		25a. REC'D BY REGISTRAR DATE MAR 30 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Hunt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

256-46-365.

1  
FOR STATE  
HEALTH DEPT.



TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health. File Page 3 with the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

09185

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3207

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY		Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE		Maryland b. COUNTY		Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X Nanjemoy (Rural)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		H. STREET ADDRESS		J. IS RESIDENCE ON A FARM?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
La Plata Hospital (Physicians Memorial)											
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
LUDMILA		( N.M.N. )		MAKOWELSKI	March	23		19 60			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years least birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	September 7, 1904	Months	Days	Hours	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
House Wife		At Home		Poland		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Gustave Schwart		Maria Poch									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		None.		Nikolai Makowelski - Nanjemoy, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Arteriosclerotic cardiovascular disease											
422.1 DUE TO											
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. (b)											
DUE TO											
(c)											
INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20f. (City or town)		(County)		(State)			
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)			
						Partial					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE		Russell S. Fisher		M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type)		Russell S. Fisher, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						3/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or country)		(State)			
Burial		3/26/1960		Rock Creek Cemetery		Washington, D.C.					
23. FUNERAL DIRECTOR		ADDRESS		24e. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Arehart Funeral Home, Inc. - La Plata, Md.				DATE MAR 30 '60		Arthur S. Krause					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3208

Item 8 Film G260 44-60 et

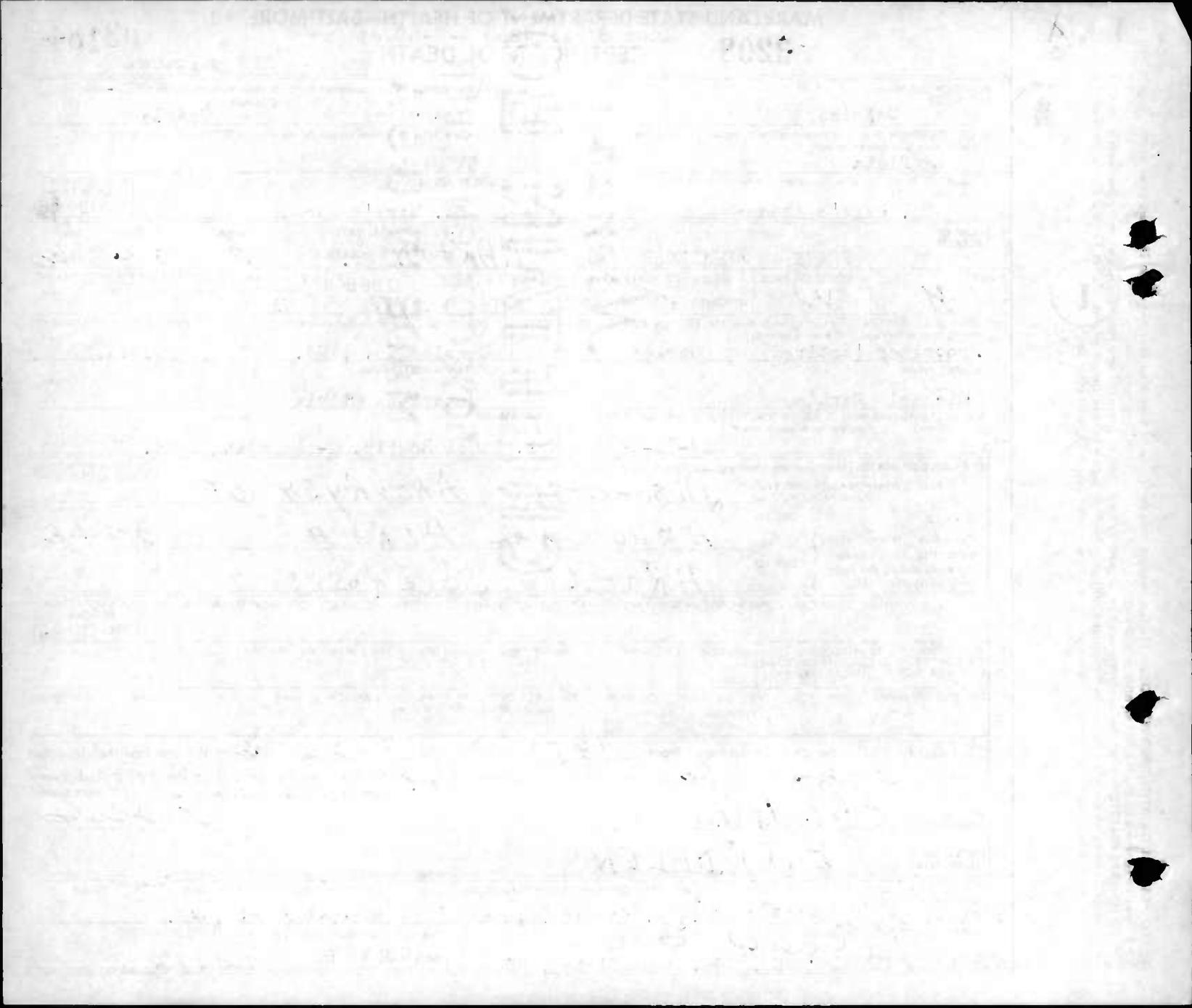
## CERTIFICATE OF DEATH

03184

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		d. STREET ADDRESS St. Mary's Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Avenue				d. STREET ADDRESS St. Mary's Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) FRANK ALEXANDER		First	Middle	4. DATE OF DEATH Last MARTIN		Month 3	Day 24	Year 1960
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1888 July 24, 1888	9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Garage		11. BIRTHPLACE (State or foreign country) Charles Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Michael Martin		14. MOTHER'S MAIDEN NAME Heneritta Olivia						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-32-1478		INFORMANT Mrs. Ethel Bowling - La Plata, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO (c) <i>Dissecting Aneurysm of Abdominal Aorta Arterio Sclerosis</i> 3-24-60								
INTERVAL BETWEEN ONSET AND DEATH								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>1958</i> , 19 to <i>3-24-60</i> that I last saw the deceased alive on <i>3-24-60</i> , and that death occurred at <i>La Plata</i> , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>La Plata, Md.</i> DATE SIGNED <i>3-24-60</i>								
ACTUAL SIGNATURE <i>E.J. Edelen</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>E.J. EDelen</i>								
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 3/29/1960		22c. NAME OF CEMETERY OR CREMATORIUM St. Thomas Cemetery		22d. LOCATION (City, town, or county) (State) Chapel Point, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard Lee -</i>		ADDRESS AREHART FUNERAL HOME, INC. * La Plata, Md.		24a. REC'D BY REGISTRAR DATE MAR 30 '60		24b. REGISTRAR'S SIGNATURE <i>Charles S. Krause</i>		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 1 and 2 should be signed by the attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

320.9

## CERTIFICATE OF DEATH

Reg. Dist. No.

03185

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b Hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Glymont		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1887		9. AGE (In years lost birthday) 73 yrs.	10. IF UNDER 1 YEAR Months Dofs Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Home Builder		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Marshall Moody		14. MOTHER'S MAIDEN NAME Adella Brown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		INFORMANT		Address John R. Moody, Rt 1 Box 60, Indian Head, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH 48hr.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3-9, 1960, to 3-11, 1960, that I last saw the deceased alive on 3-11, 1960, and that death occurred at 1142 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE F. M. JOHNSON PHYSICIAN'S NAME (Type) DATE SIGNED 3-11-60								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-15-60	22c. NAME OF CEMETERY OR CEMATORIAL St Charles Cemetery		22d. LOCATION (City, town, or county) Glymont, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland		ADDRESS		24a. REGISTRATION NUMBER 10011760	24b. REGISTRAR'S SIGNATURE C. Hunt, M. Hunt			
				DATE				

STATE OF MARYLAND

808 C

FOR STATE  
HEALTH DEPT.

**DEATH CERTIFICATE:** MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. The word "pending" in pencil in Item 18, Give Form PMS 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health.

VS. A15ME  
5M 2/57

is certificate  
word "pendin  
the Chief Medical Ex  
use of item 3 should be used  
or to banal, cremen

**TO DEPT. MEDICAL EXAMINER**  
executive certificate, written  
4 should be forwarded to the  
**TO FUNERAL DIRECTOR: Page**  
or its designated agent, prior  
VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3210 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		MARYLAND		a. STATE Maryland	b. COUNTY Charles			
La Plata		8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				Hughesville				
Physicians Memorial Hospital				d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print)		First Annie	Middle Mae	Last Moran	4. DATE OF DEATH			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
Female		white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 7, 1877	82 yrs.	Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife		Home		Maryland		US		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				
John William Raley				Elizabeth Theresa Cecil				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
(If yes, give war or dates of service)		20-26-6334		Mrs. Paul Russell, Mechanicsville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								
916.0 DUE TO Burns, 2nd and 3rd degree, back, chest, trunk Conditions, if any, which and thighs (60% of body surface) <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH</span>								
gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac decompensation, arterio-sclerotic <span style="float: right;">8½ days</span>								
DUE TO heart disease (c) <span style="float: right;">48 hrs.</span>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On Mar. 4th, 1960 clothing caught fire from overheated wood stove in home. Flames immediately extinguished by boarder but burns had occurred.								
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour 11:30 p.m.		Mar. 4 1960	While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		Home	Hughesville, Charles, Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE		<i>John H. Griffin</i>						DATE SIGNED
EXAMINER'S NAME (Type)		John H. Griffin, M.D. Acting						3-14-60
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county)		
Burial		3-16-60		Ft. Lincoln Cemetery		3201 Bladensburg Rd. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE						24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
Huntt Funeral Home, Waldorf, Md.						DATE MAR 17 '60		



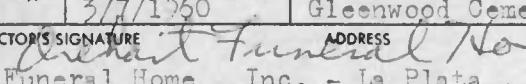
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3211

## CERTIFICATE OF DEATH

03187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Charles</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head Md</b>		c. LENGTH OF STAY IN 1b <b>55-Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head Md</b>		d. STREET ADDRESS <b>1</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Susie</b>		First <b>Inez</b>	Middle <b>Posey</b>	Lost	4. DATE OF DEATH <b>3-3-60</b>	Month	Day	Year <b>19</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W-US</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-10-1885</b>	9. AGE (In years lost birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>William Edward Morgan</b>		14. MOTHER'S MAIDEN NAME <b>Julia Towers</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Richard Polley-(Sonin Law) Indian Head Md</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>481X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Influenza-Viral</b> DUE TO (c) <b>Hypertension-Mild</b>						INTERVAL BETWEEN ONSET AND DEATH <b>30-Minutes</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>						48-Hrs. Indefinite		
20a. ACCIDENT WAS UNDEPLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>3-2-60</b> , 19, to <b>3-3-60</b> , 19, that I last saw the deceased alive on <b>3-3-60</b> , 19, and that death occurred at <b>12-45PM</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Indian Head Md</b>		
ACTUAL SIGNATURE 						DATE SIGNED		
PHYSICIAN'S NAME (Type) <b>James E. Andrews</b>								
22a. BURIAL/CREMATION: REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/7/1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Glenwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS <b>Arehart Funeral Home, Inc. - La Plata, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 14 60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thane</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03188

2212

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b RURAL and give nearest town X Doncaster	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
S. SEX Female		6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Ulysses Grant Bowman		14. MOTHER'S MAIDEN NAME Irene Elizabeth Proctor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Irene E. Proctor, Doncaster, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Presenutity - 6 Mths Prog</i>		INTERVAL BETWEEN ONSET AND DEATH 45 min.	
776X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-23-60</u> , 19 <u>1960</u> , to <u>3-23-60</u> , 19 <u>1960</u> , that I last saw the deceased alive on <u>3-23-60</u> , 19 <u>1960</u> and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>James E. Andrews, M.D.</i>		ADDRESS (Street, city or town, state) <i>Indian Head, Md.</i> DATE SIGNED <i>3-24-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/24/60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Zion Baptist Church</i>
22d. LOCATION (City, town, or county) <i>Hilltop, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Augustus Keys		24a. REC'D BY REGISTRAR DATE <i>MAR 28 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>
VS A1S (4) 1SM 9/58		2066284XVO	

MADE TO TRADE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3213

## CERTIFICATE OF DEATH

03189

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Plains		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Plains		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Bernard	Middle	Last Shelton	4. DATE OF DEATH Mar 28 1960	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH June 10, 1886	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Homes		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James W. Shelton		14. MOTHER'S MAIDEN NAME Eliza						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Robert T. Shelton, Ea Plata, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO myocardial infarction						INTERVAL BETWEEN ONSET AND DEATH 2 d		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Ganglionic Cardi-vascular Renal Disease						yes		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3-10, 1956, to 3-28, 1960, that I last saw the deceased alive on 3-25, 1960, and that death occurred at 10:15 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE <i>Reuben D. Davis</i>		M.D.		<i>Bengtje</i>				
PHYSICIAN'S NAME (Type) Reuben D. Davis		<i>Bengtje</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-30-60		22c. NAME OF CEMETERY OR CREMATORIAL Mt Olivet		22d. LOCATION (City, town, or county) Washington, D.C. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Homey Waldorf, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 31 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

64450

Reg. Dist. No.

3214

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS X HUGHESVILLE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIE (First) UNKNOWN (Middle) SWALES		4. DATE OF DEATH MARCH 24 Day Year 1960	
5. SEX MALE		6. COLOR OR RACE NEGRO	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH UNKNOWN 1888	
9. AGE (In years, months and days) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) ST. MARY'S CO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRED SWALES		14. MOTHER'S MAIDEN NAME JUHIA SCRIBNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO.		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT M. JAMES M. SWALES - INDIAN HEAD, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 12 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Died at home - spontaneous	
20c. TIME OF INJURY Month, Day, Year Hour 20 p.m. 3-24 1960		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Home 20f. (City or town) Hughesville (County) Charles (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>		22. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <u>V.B. Dettor</u>		DATE SIGNED 3-28-60	
EXAMINER'S NAME (Type) <u>V.B. DETTOR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/60	
22c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery		22d. LOCATION (City, town, or county) Bryans town, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archad Funeral Home, Inc.</u>		ADDRESS <u>1617</u> 24a. REGD BY REGISTRAR <u>Lab 61</u> DATE <u>APR 5 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Charles S. Hause</u>	

TO DEFY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If necessary, please execute certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

PHYSICAL EXAMINER: CERTIFICATE OF DEATH  
MEDICAL EXAMINER: CERTIFICATE OF DEATH

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3215 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03190

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

VS. ATSMES  
5M 9/55

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
Charles MARYLAND		a. STATE Maryland b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
La Plata		La Plata		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		
Physician's Memorial Hosp.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF -DECEASED (Type or print)	First Sharon	Middle	Last Swabb	
4. DATE OF DEATH	Month March	Day 6	Year 1960	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	
F	Col.		Jan. 26 1959	
9. AGE (In years last birthday)	10. IF UNDER 1YEAR Months Days Hours Min.			
yrs.	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
—	Washington, D.C.	U.S.A.		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME			
Wilbert Swabb	Emma			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
—	—	Wilbert Swabb, La Plata, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia and acute tonsillitis 480X DUE TO				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)				
DUE TO (c)				
INTERVAL BETWEEN ONSET AND DEATH 4 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none Secondary to influenza			
20c. TIME OF INJURY Home 3-8-1960	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City, or town) La Plata, Charles, Md. (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>				
ACTUAL SIGNATURE V. B. DETTOR	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 3-7-60
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-7-60	22c. NAME OF CEMETERY OR CREMATORIAL St. Ignatius	22d. LOCATION (City, town, or county) Bel Alton, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home, Waldorf, Md.	ADDRESS	24a. REC'D BY REGISTRAR MAR 8 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Hunt	

STATE OF HAWAII - DEPARTMENT OF HEALTH - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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TO DRAFTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any entry is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3216 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 FilmG260 4-4-60 et

Reg. Dist. No.

03191

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Charles</i> Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bell Elton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bell Elton</i>	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
<i>JAMES LESTER THOMAS</i>		Last	
4. DATE OF DEATH		Month	Day
		3	19
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
M		C	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>1935</i>
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
24 yrs.		<i>Farming</i>	<i>Md.</i>
12. CITIZEN OF WHAT COUNTRY?		<i>6-8a</i>	
13. FATHER'S NAME		14. MOTHER'S MOTHER'S NAME	
<i>James A Thomas</i>		<i>Mary F Harvey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO.	17. INFORMANT
		<i>Unknown</i>	<i>John J Thomas Laplante</i>
18. CAUSE OF DEATH [Enter only one cause per line, type (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		<i>Conflagration</i>	
916.0		DUE TO	<i>3-19-60</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)	
		DUE TO	
		(c)	<i>House demolished by fire</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>House demolished by fire</i>	
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED
Hour		While of work <input type="checkbox"/>	Not while at work <input checked="" type="checkbox"/>
2		<i>3-19 1960</i>	<i>House</i>
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town)	(County)
		<i>Bell Elton, Chas Md.</i>	<i>Baltimore Co.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED	
ACTUAL SIGNATURE <i>E. J. EDELEN M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. J. EDELEN M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 3-21-60</i>		22b. DATE THEREOF <i>3-19-60</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Agnes</i>		22d. LOCATION (City, town, or County) (State) <i>Bell Elton, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Thomas</i>		24a. REC'D. BY REGISTRAR DATE <i>MAR 30 1960</i>	
ADDRESS <i>Arthur J. Thomas</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Thomas</i>	



13192

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3217 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tompkinsville (Rural)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Tompkinsville (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	

3. NAME OF DECEASED (Type or print) PAMELA		First A. Middle Last	4. DATE OF DEATH 3 - 24 1960
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Feb. 27, 1958	9. AGE (In years last birthday) 2 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Charles Co., Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
-------------------------------------------------------------------------------------------------------	------------------------------------------	---------------------------------------------------------------	----------------------------------------

13. FATHER'S NAME Milton Thomas	14. MOTHER'S MAIDEN NAME Agnes V. Butler		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Milton Thomas - Tompkinsville, Md.	Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 085.1 DUE TO <u>Pneumonia</u>		3-23-60
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) <u>Mesles</u>	3-20-60
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)
(State)					

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
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ACTUAL SIGNATURE <i>E. J. Edelen</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 3-24-60
EXAMINER'S NAME (Type) E. J. Edelen	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/26/1960	22c. NAME OF CEMETERY OR CREMATORIAL Holy Ghost Cemetery	22d. LOCATION (City, town, or county) Issue, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archard Funeral Home, Inc.</i>		ADDRESS 7th Street, Inc. - La Plata, Md.	24a. REC'D BY REGISTRAR DATE MAR 30 '60
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>

TO DIRECTOR MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, "pending" in pencil in item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3218

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03193

Reg. Dist. No.

1  
X  
I  
O  
08  
2  
2  
VS. A15ME(5)  
5M 9/55

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hughesville</i>	c. LENGTH OF STAY IN 1b <i>1b</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hughesville</i>	d. STREET ADDRESS <i>1</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JAMES</i> First <i>EDWARD</i> Middle <i>TOYE</i> Last		4. DATE OF DEATH <i>MARCH 26 1960</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>NEGRO</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1912</i> 9. AGE (in years last birthday) <i>48</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Edward Toye</i>	
14. MOTHER'S MAIDEN NAME <i>ALICE Love</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>24-14-2904</i>		17. INFORMANT <i>Mrs. Mary Ann Toye, Hughesville, Md.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Shock and Hemorrhage</i> DUE TO <i>812X</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 min.</i> Conditions, if any, which gave rise to immediate cause (b) <i>Cerebral Hemorrhage</i> <i>1 min.</i> (c) <i>and Bilateral Compound Fractures-Tibia</i> <i>1 min.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Multiple fractures left forearm</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Pedestrian - auto accident</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>2:45 p.m.</i> 3-26-60		20d. INJURY OCCURRED While <input type="checkbox"/> Not white <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) <i>Hughesville</i> (County) <i>Charles</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>V. B. Dettor</i>	DATE SIGNED <i>3-28-60</i>		
EXAMINER'S NAME (Type) <i>V. B. DETTOR</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-30-60</i>	22c. NAME OF CEMETERY OR CREMATORIAL ST. JOHN'S A.M.E.	22d. LOCATION (City, town, or county) <i>Hughesville</i> (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Huntt Funeral Home, Waldorf, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR <i>4/4/60</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Hunt</i>

74

4

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3219

## CERTIFICATE OF DEATH

Reg. Dist. No.

03194

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>City -</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN 1b RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Waldorf</i>		d. STREET ADDRESS <i>1</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) CONSTITUTION <i>Maryland New Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>MARY GERTRUDE</i>		First <i>Mary</i>	Middle <i>Gertrude</i>	Last <i>Vernon</i>	4. DATE OF DEATH 3 Month 21 Day 1960 Year				
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>August 31, 1882</i>	9. AGE (In years lost birthday) 77 yrs.	10. IF UNDER 1 YEAR Months <i>77</i>	11. IF UNDER 24 HRS. Days <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John Dorsey Montgomery</i>				14. MOTHER'S MAIDEN NAME <i>Eliza Gates</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		INFORMANT <i>Mrs. Margaret Gardner, Waldorf, Maryland</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>334X</i>		DUE TO { (b) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. DUE TO (c)		<i>Cardio Vas Cerebro &amp; Sclerotic a Multiple sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3-14 to 3-21-60</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>3-21-60</i>	(County)	(State)			
21. I certify that I attended the deceased from <i>3-14</i> , 19 <i>60</i> , to <i>3-21</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>3-21-60</i> , 19 <i>60</i> , and that death occurred at <i>547</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED <i>3-21-60</i>					
ACTUAL SIGNATURE <i>E. Pedee</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>E. J. E. Pedee</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-21-60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St Pauls</i>		22d. LOCATION (City, town, or county) <i>Waldorf, Maryland</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Huntt Funeral Home, Waldorf, Maryland</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>C. L. Hunt</i>	24b. REGISTRAR'S SIGNATURE <i>C. L. Hunt</i>				
		DATE <i>MAR 28 '60</i>							



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3229

## CERTIFICATE OF DEATH

1-4453

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pomfret</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pomfret</i>	
d. STREET ADDRESS <i></i>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARY</i>		First <i>Anne</i>	Middle <i>WILLETT</i>
4. DATE OF DEATH <i>MARCH 31 1960</i>		Month <i>MARCH</i>	Day <i>31</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>WIDOWED</i> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 11, 1877</i>
9. AGE (In years last birthday) <i>82 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	12. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>Anthony Winkler</i>	14. MOTHER'S MAIDEN NAME <i>Emily Adams</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>Walter Willett, White Plains, Md.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i></i>	
DUE TO <i>Congestive Heart Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 mo.</i>	
DUE TO <i>Arteriosclerotic Heart Disease</i>		years <i></i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Cerebrovascular Accident</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, note by medical examiner) <i>No accident</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No injury</i>	
20c. TIME OF INJURY Hour <i>o. m.</i>	Month, Day, Year <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>
20f. (City or town) <i>Waldorf, Charles, Md.</i>		(County) <i>Charles</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>2-7</i> , 19 <i>60</i> , to <i>3-31</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>3-29</i> , 19 <i>60</i> , and that death occurred at <i>11:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>V.B. Dettor</i>	M.D.		ADDRESS (Street, city or town, state) <i>Box 397 La Plata</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-4-60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Josephs</i>	22d. LOCATION (City, town, or county) <i>Pomfret, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 6 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

## CERTIFICATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03195

3221

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b>		3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaPlata Md.</b>		c. LENGTH OF STAY IN 1b <b>34-Days</b>		X <b>Rural Waldorf Md</b>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital, LaPlata Md</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Mildred</b>	Middle <b>Sara</b>	Last <b>Willett</b>	4. DATE OF DEATH <b>3-10-60</b>	Month	Day	Year <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-16-18</b>	9. AGE (In years last birthday) <b>41</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife WORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>American-USA.</b>			
13. FATHER'S NAME <b>John Willett.</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Willett</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>John Willett, (Brother) Waldorf Md</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Cirrhosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Indefinite</b>			
581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) <b>Chronic Gastritis</b>				Indefinite			
DUE TO		(c) <b>Chronic Ulcers of Duodenum</b>				Indefinite			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Patient had marked ascites which recurred immediately after tapping</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Indian Head Md		(County)	(State)
21. I certify that I attended the deceased from <b>2-5-60</b> , 19, to <b>3-10-60</b> , 19, that I last saw the deceased alive on <b>3-10-60</b> , 19, and that death occurred at <b>7:45PM</b> M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Indian Head Md</b>		DATE SIGNED <b>3-12-60</b>	
ACTUAL SIGNATURE <i>James E. Andrews</i>		M.D.							
PHYSICIAN'S NAME (Type) <b>James E. Andrews MD.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-14-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OAKLAND Cem.</b>		22d. LOCATION (City, town, or county) <b>Waldorf, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>MAR 17 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hunt</b>			
VS A1S (4) 15M 9/55				DATE					

## WISCONSIN STATE DEPARTMENT OF HEALTH - BOSTON

## CERTIFICATE OF DEATH

CHAPIN

MATERIAL

RECEIVED

MURKIN, JOHN

10-12

0-10-8

John W. Murkin

MURKIN, JOHN

John W. Murkin

MURKIN, JOHN

John W. Murkin

MURKIN, JOHN

John W. Murkin

Dr. Francis (assistant) Hellier, M.D.

John W. Murkin

MURKIN

John W. Murkin

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

03196

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAPLATA</b>		c. LENGTH OF STAY IN 1b <b>3 mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BOWLING'S HOTEL, Charles St.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCE FREDERICK</b>	
d. STREET ADDRESS _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Bertha</b>	Middle <b>Ann</b>	Last <b>YOUNG</b>
4. DATE OF DEATH <b>March 15 1960</b>	Month Month	Doy Days	Year Hours
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 30 1879</b>
9. AGE (In years lost birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>Bowens, Md</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Berri Stafford</b>	
14. MOTHER'S MAIDEN NAME <b>Tda Cusick</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>VIOLET YOUNG - PRINCE FREDERICK, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <b>hypertension, cardiovascular disease 20 yrs.</b>			
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>481X INFLUENZA in January, never fully recovered.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>29 Jan 1960</b> to <b>15 Mar 1960</b> , that I last saw the deceased alive on <b>15 Mar 1960</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur O. Woody</b>		ADDRESS (Street, city or town, state) <b>JARWOOD CLINIC</b>	
PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY</b>		DATE SIGNED <b>15 Mar 60.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Mar. 17, 1960</b>		22b. DATE THEREOF <b>Asbury Cemetery</b>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Arthur O. Woody &amp; Son - Mortuary, Inc.</b>		22d. LOCATION (City, town, or county) <b>Berthia, Calvert Co - Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. O. Hackness &amp; Son - Mortuary, Inc.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 17 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

